STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

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F000000	This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Compliant IN00127901. Complaint IN00127901 - Substantiated. Federal/state deficiency related the allegation is cited at F-166. Survey dates: May 28, 29, 30, 31, June 3, & 4, 2013 Facility number: 000035 Provider number: 155089 AIM number: 100266250 Survey team: Angel Tomlinson RN TC Sharon Lasher RN Barbara Gray RN Leslie Parrett RN Census bed type: SNF/NF: 53 Total: 53 Census payor type: Medicare: 5 Medicaid: 39 Other: 9 Total: 53	F000000	F0000Preparation and/or execution of This Plan of Correction in generalor any corrective action set forth herein, in particular, does not constitutean admission or agreement by Heritage House of New Castle of the facts allegedor the conclusions set forth in the statement of deficiencies.The Plan of Correction and specific corrective actions are prepared and/or executedsolely because of provisions of federal and/or state laws. Heritage House desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective July 4, 2013 .This building respectfully requests consideration for paper compliance from the Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 6/13/13 by Suzanne Williams, RN			

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F000166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, interview and record review, the facility failed to resolve grievances related to incontinence care not being done timely for 1 of 1 resident reviewed for activities of daily living, cleanliness and grooming of 1 resident who met the criteria for activities of daily living, cleanliness and grooming (Resident #D) Finding include: Interview with Resident #D's family member on 5-28-13 at 10:01 a.m. indicated she visited Resident #D almost on a daily basis and all different hours of the day and night. The family member indicated Resident #D did not receive assistance with toileting needs. The family member indicated Resident #D was found wet with urine and soiled with bowel movement frequently. The family member indicated she felt there were not enough staff working at the facility, and during the weekends and on night shift there were times Resident #D would be	F000166	Heritage House will continue to ensure all residents have the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.1 A grievance (complaint/ concern) form will be filled out for resident D's family and handled appropriately. Attachment #3. Resident D's family member alleged grievances regarding incontinence care would have been promptly investigated and resolved if found to be factual.The family member of Resident D has filled out two previous resident concern/complaint forms in the past and these grievances were handled to her satisfaction. She was informed at admission how to file a grievance. Attachment #4 A,B,C,D2. Any resident with a grievance has the potential to be affected. Complaint/concern forms will be placed at each nurses station.3. All staff will be inserviced July 1, 2013 re: complaints/concerns and how these are to be handled. 4. Social Services will monitor all complaint/concerns weekly for 3 months and monthly for 3	07/04/2013

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	incontinent and the family member would not be able to find any staff available to change the resident . The family member indicated the resident was found to have urine soaked clothes and bowel movement all the way up her back on several occasions. Family member indicated Resident #D was unable to clean herself up. The family member indicated she had timed how long it took to get assistance and it had been up to 40 minutes. The family member indicated she had talked with the Director Of Nursing (DON) about these concerns and nothing ever gets resolved. The family member indicated nothing had changed since she had reported her concerns to the DON. The family member indicated she had talked with the DON about these concerns within the past two months. The family member indicated the facility had urine odor almost every day when she visits. The family member indicated the facility had never had her fill out a grievance form. The family member indicated a lot of times when she would come to visit, Resident #D would be sitting in the dining room wet with urine and she wondered how long had Resident #D had been sitting in the dining room wet. During the interview there was a strong urine odor observed outside		months. Social Services will randomly question 3 residents or their family/responsible party weekly for 3 months and 6 residents or their family/responsible party monthly for 3 months. Results will be reported to the QA committee for review/recommendations. Attachment #5.IDR:Resident #D daughter did not file a grievance with anyone at the facility. See attachments.	

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	Resident #D's bedroom. Review of the record of Resident #D on 5-31-13 at 2:03 p.m. indicated the resident's diagnoses included, but were not limited to, hypothyroidism, Alzheimer's dementia, depression, urinary incontinence, insomnia, diarrhea and leg pain. The Minimum Data Set (MDS) assessment for Resident #D dated 4-25-13 indicated the following: the resident's BIMS score (Brief Interview for Mental Status) was 3- severe impairment, the resident required extensive assistance of one person for toileting needs, was frequently incontinent of urine and always incontinent of her bowel. Interview with the Social Service Director S.S.D. on 5-30-13 at 10:35 a.m. indicated the facility had not received any grievances on incontinent care not being done timely or lack of staffing. The S.S.D. indicated if a resident or a family member had complained about these issues a grievance form would have been filled out. During interview with the DON on 6-3-13 at 10:57 a.m. regarding if a grievance form had been completed			

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	for Resident #D's family member's concerns about the resident being found wet with urine and soiled with bowel movement and the facility not having enough staff to give assistance with the resident's toileting needs, the DON indicated she did not fill out a grievance form. The DON indicated the S.S.D. was the one who filled out the grievance forms. The DON indicated Resident #D's family had reported these concerns to her but she felt like it was just a conversation and so she did not need to fill out a grievance. The DON indicated she went over the number of staff the facility had on each shift with Resident #D's family member and the family member appeared to be satisfied with this. Review of the "resident/family concerns or complaints" policy provided by the S.S.D. on 5-31-13 at 8:55 a.m. indicated the purpose of the policy was to ensure all resident/families will have means to communicate any and all concerns or complaints. When a resident or family member report a complaint or concern a resident/family concern form was started by the nurse on duty or Social Services. The resident/family concern form included, but were not limited to the following:			

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	the date of the concern, name of the person filing the concern, a description of the concern, the department responsible to investigate the concern, a plan for a resolution of the concern and a follow up with the resident/family two weeks after the resolution date. This federal tag relates to complaint IN00127901. 3.1-7(a)(2)			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F000225	Heritage House will continue to	07/04/2013

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	review, the facility failed to protect residents, complete a thorough investigation and report an allegation of verbal abuse for 1 of 1 resident who met the criteria for abuse (Resident #23). Finding includes: Interview with Resident #23 on 5-28-13 at 9:20 a.m. indicated staff had yelled and been rude to her. Resident #23 indicated CNA #1 had brought her breakfast tray in one morning while she was asleep. Resident #23 indicated CNA #1 yelled at her "do you want this d--- tray or not." The resident indicated she started moving her stuff off her bedside table and CNA #1 said "hurry up". The resident indicated she told the CNA "I was going as fast as I could." Resident #23 indicated she reported the incident to the Director Of Nursing the same day it happened. Resident #23 indicated CNA #1 does still work at the facility but does not assist her anymore with care. Resident #23 indicated she did not know the date of the incident but it was in the last nine months. Resident #23 indicated she felt like CNA #1 "bit her head off" for no reason. Review of the record of Resident #23		ensure that all alleged violations of verbal abuse are thoroughly investigated and prevent further potential abuse while the investigation is in process. All allegations will be reported to officials in accordance with State law.1. The alleged incident of verbal abuse was reported to surveyors on 05/28/2013. The alleged allegation of abuse was thoroughly investigated when reported to the DON the day after Resident #23 stated it had occurred. On the date Resident #23 reported to surveyors it had occurred and she reported it to the DON is inaccurate. Per facility investigation the later alleged statement did not occur. The CNA #1 had a witness, CNA #2 that she did not say "do you want this d--n tray or not". In fact witness CNA #2 informed charge nurse that Resident #23 was yelling and told CNA#1 to "kiss her a--". At no time on the date of the alleged incident did Resident #23 ever speak to the DON. CNA#1 left at 2:00PM on the date of the alleged incident and did not return until a thorough investigation had been done. Resident #23 left a note for the DON to see her the next day. She then made the first allegation of the incident, which was immediately investigated. Resident #23 also changed her allegations, giving more than one description of what she alleged. Resident #23 had a care	

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	on 5-30-13 at 10:50 a.m. indicated the resident's diagnoses included, but were not limited to, morbid obesity, restless leg syndrome, osteoarthritis, edema, depression, anxiety, back pain, cellulitis, urinary incontinence, insomnia, psychotic agitation, pulmonary hypertension, anemia, urinary retention. The care plan for Resident #23, with a review date of 1-9-13, indicated the resident made false accusations about the facility and staff to her family. The interventions included, but were not limited to, remind the resident that legitimate complaints and concerns will be addressed and intervene as needed and have 2 staff members approach the resident when speaking with her to ensure staff protection from accusations. The nursing note for Resident #23 dated 3-13-13 at 9:30 a.m. indicated the resident was yelling at staff and Social Services was notified. The Minimum Data Set (MDS) assessment for Resident #23, dated 4-25-13 indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.		plan than includes false accusations.2. Any resident making an accusation of verbal abuse has the potential to be affected. All residents making any type of accusation of alleged verbal abuse, even if care planned they make false accusations, will be reported to the appropriate officials in accordance with State law.3. All staff will be inserviced on the proper reporting of alleged abuse/any & all types of abuse on 7/1/2013. All new hires will be educated on abuse prohibition and proper reporting.4. All accusations of abuse will be investigated and reported to the apppropriate State agencies.. Attachment #6A-C. The DON or designee will monitor reportable log weekly for 3 months then monthly for 3 months to ensure complinace.These reportables will be reported to the QA Committee and recommendations followed.	

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	The psychology progress note for Resident #23 dated 5-2-13 indicated the resident was alert and oriented fully times 3. The resident reported feeling occasionally depressed. Interview with the DON on 5-30-13 at 8:29 a.m. indicated the facility had not had any reportable incidents to report to the Department of Health related to abuse/neglect in past 6 months except resident to resident altercations. When queried about Resident #23 reporting a CNA had cussed and yelled at her, the DON indicated she had a "soft file" on the incident, but had not reported it to the Department of Health. The DON indicated a soft file was something the facility felt like they did not need to report to the Department of Health but did need to keep a file on the situation. The DON indicated on 3-13-13 the resident had left a note requesting to talk with her. The DON indicated when she went to the resident's room to talk with her, the resident reported that she did not want CNA #1 in her bedroom anymore because she was mean. The DON indicated the resident reported that when CNA #1 brought her breakfast tray in that morning, she was asleep and did not wake up right away and CNA #1 said to the resident			

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	"do you want this d--- tray?" The DON indicated she clarified with the resident that CNA #1 had cussed at her, and the resident indicated yes she had. The DON indicated Resident #23 indicated after CNA #1 cussed at her, the resident began throwing things and cussing at CNA #1. The DON indicated the resident began crying during their conversation and saying she did not understand why everyone hated her and that she tried to get along with everyone. The DON indicated when she questioned CNA #1 the CNA indicated she took Resident #23's breakfast tray in and the resident was asleep. CNA #1 indicated she said the resident's name three times and then the resident said to her I don't know what your problem is. The CNA indicated the resident became upset and started throwing things and told her to kiss her a--. CNA #1 indicated she did not say anything to the resident and walked out of the room. The DON indicated CNA #2 was standing in the hallway during the incident and heard what happened, and both CNA's indicated that CNA #1 did not cuss at Resident #23. The DON indicated there had to be two staff in the resident's room at all times. The DON indicated the facility did not report this incident to the Department of Health			

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	because Resident #23 had it care planned that she made false accusations. The DON indicated she did not interview any other residents related to this situation and she did not suspend CNA #1. The DON indicated CNA #1 does not care for Resident #23 anymore. Interview with CNA #1 on 5-30-13 at 9:17 a.m. indicated she took Resident #23's breakfast tray in her room on 3-13-13 and the resident was laying in bed looking out her window. CNA #1 indicated she said the resident's name three times and then the resident "blew up" and screamed at her to stop yelling. CNA #1 indicated the resident told her to get the h--- out of her room. CNA #1 indicated CNA #2 was in the hallway and heard the whole situation. CNA #1 indicated she reported to one of the nurses about the incident but could not remember which one. Interview with CNA #2 on 5-30-13 at 9:38 a.m. indicated she was passing trays with CNA #1 on 3-13-13. CNA #2 indicated she was in another resident's room passing a tray when she heard Resident #23 yelling so she stood in the hallway and listened. CNA #2 indicated she did not hear what happened prior to Resident #23			

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	yelling because she was in another resident's room. CNA #2 indicated she did not hear CNA #1 cuss at the resident. CNA #2 indicated she and CNA #1 reported the incident to the nurse but she could not remember which nurse it was. Interview with LPN #4 on 5-31-13 at 9:38 a.m. indicated she was the nurse on 3-13-13 when the incident happened with Resident #23. LPN #4 indicated that CNA #1 and CNA #2 reported to her that Resident #23 was upset. LPN #4 indicated she talked with Resident #23 on 3-13-13 and the resident indicated that CNA #1 cussed at her. LPN #4 indicated the resident had said something about CNA #1 asking her if she wanted her d--- tray. LPN #4 indicated she told CNA #1 not to care for Resident #23 anymore and reported the incident to the DON as soon as she got done talking with Resident #23. When queried if CNA #1 continued to work on 3-13-13 LPN #4 indicated yes she did continue to work on 3-13-13 because Resident #23 had it care planned of making false accusations. Interview with Resident #23 on 5-30-13 at 10:00 a.m. indicated the when CNA #1 cussed at her she was shocked. Resident #23 indicated she			

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	had always gotten along with CNA #1 and she thought maybe the CNA was in a bad mood that day. Resident #23 indicated she felt like CNA #1 should have gotten in trouble for cussing at her but she was satisfied that she no longer cared for her. Resident #23 indicated LPN #4 was the one that told her that CNA #1 would not be caring for her anymore. Review of the "Incidents of alleged abuse" policy provided by the Social Service Director (S.S.D.) on 5-31-13 at 8:55 a.m. indicated the residents residing in the facility will be treated with dignity and respect in accordance with their individual needs. "Verbal abuse is defined as the use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance". The procedure for allegations of abuse included, but were not limited to, a thorough investigation will be initiated of the allegations to gather pertinent information and verify the occurrence, if the suspected abusive individual is an employee, it it the responsibility of the supervisor at the time of the incident, if other than the Administrator, to suspend the abusive employee until the incident can be			

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	155089	A. BUILDING 00 B. WING	06/04/2013

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	fully investigated and all incidents of resident abuse will be reported to the Indiana State Department of Health. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement the policy of abuse prevention by not protecting residents, implementing an investigation and reporting an allegation of verbal abuse for 1 of 1 resident who met the criteria for abuse (Resident #23). Finding includes: Interview with Resident #23 on 5-28-13 at 9:20 a.m. indicated staff had yelled and been rude to her. Resident #23 indicated CNA #1 had brought her breakfast tray in one morning while she was asleep. Resident #23 indicated CNA #1 yelled at her "do you want this d--- tray or not." The resident indicated she started moving her stuff off her bedside table and CNA #1 said "hurry up". The resident indicated she told the CNA "I was going as fast as I could." Resident #23 indicated she reported the incident to the Director Of Nursing the same day it happened. Resident #23 indicated CNA #1 does	F000226	Heritage House will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.1.This was repoted to the ISDH on 5/28/13. An investigation was done 3/14/2013, on an allegation of alleged verbal abuse re: resident # 23, who has a Plan of Care stating she makes false accusations,that was not substantiated.2. Any resident who makes an allegation of verbal abuse has the potential to be affected. All resident allegations/concerns were reviewed for the last 6 month. All resident allegations of any type of abuse will be reported to the appropriate State agencies within 24hours of the incident and an investigation will be done on all allegations. 3.All resident allegations of any type of abuse will be reported to the appropriate State agencies within 24 hours of the incident and an investigation will be done on all allegations. See attachments # 5 & 6. All staff will be inserviced on abuse on 7/1/2013.4. The DON or her designee will monitor all ISDH	07/04/2013

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	still work at the facility but does not assist her anymore with care. Resident #23 indicated she did not know the date of the incident but it was in the last nine months. Resident #23 indicated she felt like CNA #1 "bit her head off" for no reason. Review of the record of Resident #23 on 5-30-13 at 10:50 a.m. indicated the resident's diagnoses included, but were not limited to, morbid obesity, restless leg syndrome, osteoarthritis, edema, depression, anxiety, back pain, cellulitis, urinary incontinence, insomnia, psychotic agitation, pulmonary hypertension, anemia, urinary retention. The care plan for Resident #23, with a review date of 1-9-13, indicated the resident made false accusations about the facility and staff to her family. The interventions included, but were not limited to, remind the resident that legitimate complaints and concerns will be addressed and intervene as needed and have 2 staff members approach the resident when speaking with her to ensure staff protection from accusations. The nursing note for Resident #23 dated 3-13-13 at 9:30 a.m. indicated the resident was yelling at staff and		reportables weekly for 3 months, monthly for 3 months, then ongoing. Social Service Director or designee will monitor all complaints/concerns/grievances weekly for 3 months, monthly for 3 months, then ongoing. Findings will be reported to the QA Committee for review and recommendations. See attachments # 5 & 6. All staff will be inserviced on abuse on 7/1/2013.	

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	Social Services was notified. The Minimum Data Set (MDS) assessment for Resident #23, dated 4-25-13 indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact. The psychology progress note for Resident #23 dated 5-2-13 indicated the resident was alert and oriented fully times 3. The resident reported feeling occasionally depressed. Interview with the DON on 5-30-13 at 8:29 a.m. indicated the facility had not had any reportable incidents to report to the Department of Health related to abuse/neglect in past 6 months except resident to resident altercations. When queried about Resident #23 reporting a CNA had cussed and yelled at her, the DON indicated she had a "soft file" on the incident, but had not reported it to the Department of Health. The DON indicated a soft file was something the facility felt like they did not need to report to the Department of Health but did need to keep a file on the situation. The DON indicated on 3-13-13 the resident had left a note requesting to talk with her. The DON indicated when she went to the			

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	resident's room to talk with her, the resident reported that she did not want CNA #1 in her bedroom anymore because she was mean. The DON indicated the resident reported that when CNA #1 brought her breakfast tray in that morning, she was asleep and did not wake up right away and CNA #1 said to the resident "do you want this d--- tray?" The DON indicated she clarified with the resident that CNA #1 had cussed at her, and the resident indicated yes she had. The DON indicated Resident #23 indicated after CNA #1 cussed at her, the resident began throwing things and cussing at CNA #1. The DON indicated the resident began crying during their conversation and saying she did not understand why everyone hated her and that she tried to get along with everyone. The DON indicated when she questioned CNA #1 the CNA indicated she took Resident #23's breakfast tray in and the resident was asleep. CNA #1 indicated she said the resident's name three times and then the resident said to her I don't know what your problem is. The CNA indicated the resident became upset and started throwing things and told her to kiss her a--. CNA #1 indicated she did not say anything to the resident and walked out of the room. The DON			

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	indicated CNA #2 was standing in the hallway during the incident and heard what happened, and both CNA's indicated that CNA #1 did not cuss at Resident #23. The DON indicated there had to be two staff in the resident's room at all times. The DON indicated the facility did not report this incident to the Department of Health because Resident #23 had it care planned that she made false accusations. The DON indicated she did not interview any other residents related to this situation and she did not suspend CNA #1. The DON indicated CNA #1 does not care for Resident #23 anymore. Interview with CNA #1 on 5-30-13 at 9:17 a.m. indicated she took Resident #23's breakfast tray in her room on 3-13-13 and the resident was laying in bed looking out her window. CNA #1 indicated she said the resident's name three times and then the resident "blew up" and screamed at her to stop yelling. CNA #1 indicated the resident told her to get the h--- out of her room. CNA #1 indicated CNA #2 was in the hallway and heard the whole situation. CNA #1 indicated she reported to one of the nurses about the incident but could not remember which one.			

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	Interview with CNA #2 on 5-30-13 at 9:38 a.m. indicated she was passing trays with CNA #1 on 3-13-13. CNA #2 indicated she was in another resident's room passing a tray when she heard Resident #23 yelling so she stood in the hallway and listened. CNA #2 indicated she did not hear what happened prior to Resident #23 yelling because she was in another resident's room. CNA #2 indicated she did not hear CNA #1 cuss at the resident. CNA #2 indicated she and CNA #1 reported the incident to the nurse but she could not remember which nurse it was. Interview with LPN #4 on 5-31-13 at 9:38 a.m. indicated she was the nurse on 3-13-13 when the incident happened with Resident #23. LPN #4 indicated that CNA #1 and CNA #2 reported to her that Resident #23 was upset. LPN #4 indicated she talked with Resident #23 on 3-13-13 and the resident indicated that CNA #1 cussed at her. LPN #4 indicated the resident had said something about CNA #1 asking her if she wanted her d--- tray. LPN #4 indicated she told CNA #1 not to care for Resident #23 anymore and reported the incident to the DON as soon as she got done talking with Resident #23. When queried if CNA #1 continued to work			

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	on 3-13-13 LPN #4 indicated yes she did continue to work on 3-13-13 because Resident #23 had it care planned of making false accusations. Interview with Resident #23 on 5-30-13 at 10:00 a.m. indicated the when CNA #1 cussed at her she was shocked. Resident #23 indicated she had always gotten along with CNA #1 and she thought maybe the CNA was in a bad mood that day. Resident #23 indicated she felt like CNA #1 should have gotten in trouble for cussing at her but she was satisfied that she no longer cared for her. Resident #23 indicated LPN #4 was the one that told her that CNA #1 would not be caring for her anymore. Review of the "Incidents of alleged abuse" policy provided by the Social Service Director (S.S.D.) on 5-31-13 at 8:55 a.m. indicated the residents residing in the facility will be treated with dignity and respect in accordance with their individual needs. "Verbal abuse is defined as the use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance". The procedure for allegations of abuse included, but were not limited to, a			

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	thorough investigation will be initiated of the allegations to gather pertinent information and verify the occurrence, if the suspected abusive individual is an employee, it it the responsibility of the supervisor at the time of the incident, if other than the Administrator, to suspend the abusive employee until the incident can be fully investigated and all incidents of resident abuse will be reported to the Indiana State Department of Health. 3.1-28(a)			

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F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to provide dignity for 1 resident of 10 residents observed for dining. (Resident #7) Findings include: The record of Resident #7 was reviewed on 5/30/13 at 9:40 a.m. Resident #7's diagnoses, included but were not limited to, senile dementia and anxiety. Resident #7's Quarterly, MDS (Minimum Data Set), assessment, dated 4/28/13 indicated Resident #7 cognition was severely impaired, never/rarely made decisions and needed extensive assistance, one person with eating. Resident #7's, care plan, dated 4/2/12 with a update of 5/30/13, indicated "Problem #1, resident presents the potential for weight lost and problem #2, eating with fingers. Goal, the resident to maintain weight through	F000241	Heritage House will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.1. Resident #7 has been evaluated and treated by both speech and occupational therapy. Resident #7 had a stage 4 decub when admitted, which has healed and her wt. has increased from 86 to 100.7 lbs. We have contacted the resident's family re; her eating habits. Family stated resident has eaten with her finger's for a long time. They also tried to correct this but failed. The have no concerns re: resident eating with her fingers as it is her choice. Ombudsman was also contacted re: Resident #7 eating with her fingers. It is her opinion that the resident has the right to eat with her fingers. A spoon is provided on Resident #7 food tray, she refuses to use it. She will at times allow staff to put the edge of the spoon in her mouth but will not eat. Staff does attempt to feed resident #7. Resident #7 has only allowed staff to assist her a very few times, this is extremely rare. The	07/04/2013

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	next 90 days review. Interventions, honor the physician's ordered diet, pureed, monitor weight weekly for 4 weeks or until stable, then monthly, send dessert bowls on her tray resident prefers to eat with her fingers. Comment, 1/21/13, resident continues to eat with fingers. She starts out with spoon but prefers fingers." Resident #7's care plan, dated 2/20/13, "Problem, resident eats meals with her fingers and at times sucks on fingers. Goal, resident will be allowed to eat with her fingers, as she desires, as well as episodes of sucking on her fingers. Intervention, ensure that her hands are clean and provide "finger-foods", cups, or bowls for resident to use. Resident #7's physician recapitulation orders, dated 6/13, indicated "no added salt/pureed diet." On 5/28/13 at 7:34 a.m., Resident #7 was in the assist dining room. She had 3 dessert bowls of pureed food and would put her right finger in one of the bowls and the suck on her finger. She ate approximately 1/2 of her food by continuing to put her finger in the food and licking her		DON, MDS Coordinator and other nurses have had no success feeding the resident. This is a resident choice issue. See attachment #7.2. Any resident who refuses to be assisted with meal, refuses to use eating utensils, must be on a pureed diet and insists to feed self with her fingers is at risk. All residents will be audited for their preferred eating habits. Anyone who meets the aforementioned criteria will be evaluated by speech therapy and occupational therapy to see if their eating habits can be changed, if resident so desires.3. All residents who eat pureed food with their fingers will be screened by speech therapy and occupational therapy to see if treatment can correct the way the resident eats or if the diet can be upgraded. If treatment is indicated it will be provided. 4. All residents will be monitored to identify any resident who eats pureed food with their fingers, weekly for 3 months then monthly for 3 months, then as needed. All residents identified will be referred to speech therapy and occupational therapy for evaluation &/or treatment. The Therapy Dept. Mgr. will report findings and treatments to the QA Committee quarterly for 6 months, then as needed.IDR: There is no evidence that the facility did not promote care for resident #7 in a manner & enviroment that maintained or	

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	finger During an interview on 5/28/13 at 7:45 a.m., CNA #1 indicated "we try not to feed her so we can get her to eat with a spoon instead of us feeding her because she will just eat and eat until she gets sick when we feed her." On 5/29/13 at 11:58 a.m., Resident #7 was observed eating lunch by putting her finger in different dessert bowls with pureed food, mashed potatoes, pudding ground turkey. A spoon was provided but she did not use it. During an interview on 5/29/13 at 12:10 p.m., CNA #10 indicated "we don't feed her because she will eat so much she will get sick." On 5/31/13 at 12:20 p.m. CNA #6 was observed feeding Resident #7 with a spoon during the entire meal without difficulty. 3.1-3(t)		enhanced resident's dignity & respect in full recognition of her individually. It is the residents right to eat in the manner they choose. See attached.	

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure necessary care and treatment were provided for 3 of 6 residents reviewed for constipation. (Resident #16, #56 and #18) Findings include: 1.) The record of Resident #16 was reviewed on 5/30/13 at 8:18 a.m. Resident #16's diagnoses, included but were not limited to, chronic pain and constipation. Resident #16's Quarterly MDS (Minimum Data Set), assessment, dated 1/15/13 indicated the following: - BIMS (Brief Interview for Mental Status), scored 15, with a score of 13-15, indicating intact cognition - bed mobility, total dependence of two staff - transfer, total dependence of two staff - walk in room or corridor, activity did not occur	F000309	Heritage House will continue to ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. 1. Residents # 16, #56, #18, have been assessed, BM's monitored and laxitives given if indicated. 2. All residents with the diagnosis of constipation have the potential to be affected.. These residents have been assesed and laxatives given if indicated. 3. A new procedure for monitoring BM's and the administration of MOM/laxatives has been implemented . See attachment #8A-C 4.The Don or her designee will monitor ADL Books and BM log 5 times weekly times 3 months, then weekly times 3 months, then PRN. The information wil be taken to the QA Committee for any needed action or recommendations.	07/04/2013

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	- toilet use, total dependence of two staff - always continent of urine and bowel Resident #16's physician's recapitulation orders, dated 6/13, indicated the following: - Colace (stool softener), 100 mg (milligrams), by mouth, daily - Lasix (diuretic), 20 mg, by mouth, daily - Oxycontin (narcotic analgesic), 80 mg, by mouth, 2 times a day - Dulcolax (laxative) suppository, rectally, daily, as needed - Milk of Magnesia (laxative), by mouth, daily, as needed A document titled "ADL (activities of daily living), form, dated April 2013, indicated for the month of April, 2013, Resident #16 did not have a bowel movement on April, 12, 13, 14, 15, 16 or 17, 2013. (6 days without a bowel movement). Resident #16' April, 2013, MAR (Medication Administration Record), indicated PRN (as needed) laxatives were not given during the days of no bowel movements for Resident #16. A document titled "ADL, form, dated May 2013, indicated for the month of May, 2013, Resident #16 did not have			

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	155089	A. BUILDING 00 B. WING	06/04/2013

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	a bowel movement on May, 24, 25, 26, 27, 28 and 29, 2013. (6 days without a bowel movement). Resident #16' May, 2013, MAR, indicated PRN, laxatives were not given during the days of no bowel movements for Resident #16. During an interview on 5/31/13 at 8:40 a.m., Resident #16 indicated "yes, I am constipated at times and it makes my stomach hurt but they do give me a suppository when I get to feeling real bad and it helps." During an interview on 6/3/13 at 1:10 p.m., LPN #2, indicated "we have a policy and a laxative should have been given if they did not have a bowel movement in 3 days." 2.) Resident #56's record was reviewed on 5/31/13 at 2:18 P.M. Diagnoses included but were not limited to, Alzheimer's Disease, dementia with agitation and anxiety, and constipation. Resident #56's quarterly Minimum Data Set assessment, dated 5/1/13, indicated he was usually understood and sometimes understood others. He scored 3 on his Brief Interview for Mental Status, indicating he was			

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	severely impaired for his cognitive decision making. He was always incontinent of bowel. Resident #56's physician recapitulation order for May, 2013, indicated the following order: Milk of Magnesia Regular Strength 400 milligrams (mg)/ 5 milliliters (ml) - Give 30 ml by mouth daily as needed (PRN) for constipation. Resident #56's Activity of Daily Living Form for Bowel Elimination indicated Resident #56 had not had a bowel movement during the following time frames: March 11, 12, 13, and 14, 2013; April 19, 20, 21, and 22, 2013; May 3, 4, 5, and 6, 2013; May 28, 29, 30, and 31, 2013. No documentation was available in Resident #56's record he had received his Milk of Magnesia PRN, or any additional bowel stimulant, during the above noted time frames. An interview with LPN #7, on 6/3/13 at 12:23 P.M., indicated the facility's procedure for bowel management, was to give a resident prune juice in the morning and Milk of Magnesia in the evening (unless results were achieved from the prune juice), if a resident had not had a bowel			

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	movement for 3 days. LPN #7 indicated the night shift nurses were responsible to review the resident's Activity of Daily Living Form for Bowel Elimination and report to the day shift nurses, the need to begin the bowel management procedure. LPN #7 indicated Resident #56 received prune juice every morning with his breakfast tray. A review of Resident #56's meal ticket indicated he received 4 ounces of prune juice every morning with his breakfast. On 6/4/13 at 8:49 A.M., LPN #7 indicated she was unable to locate any documentation Resident #56 had received his Milk of Magnesia PRN, or any additional bowel stimulant, except his prune juice, during the following time frames: March 11, 12, 13, and 14, 2013; April 19, 20, 21, and 22, 2013; May 3, 4, 5, and 6, 2013; May 28, 29, 30, and 31, 2013. 3.) Resident #18's record was reviewed on 6/4/13 at 9:33 A.M. Diagnoses included but were not limited to, status post motor vehicle accident with severe brain injury, and constipation. Resident #18's quarterly Minimum			

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	Data Set assessment, dated 5/1/13, indicated he was usually understood and understood others. He scored 9 on his Brief Interview for Mental Status, indicating he was moderately impaired for his cognitive decision making. He was always incontinent of bowel. Resident #18's physician recapitulation order for June, 2013, indicated the following orders: Milk of Magnesia Regular Strength 400 mg/5 ml - Give 30 ml by mouth every other day PRN for constipation. Bisacodyl suppository 10 mg - Insert 1 suppository rectally daily PRN for constipation if no bowel movement for 3 days. Resident #18's Activity of Daily Living Form for Bowel Elimination indicated Resident #18 had not had a bowel movement during the following time frames: March 3, 4, 5, 6, and 7, 2013; April 27, 28, 29, and 30, 2013; May 6, 7, 8, 9, and 10, 2013; May 18, 19, 20, and 21, 2013. No documentation was available in Resident #18's record, he had received any prune juice, his Milk of Magnesia PRN, his Bisacodyl suppository PRN, or any additional bowel stimulant, during the above			

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	noted time frames. On 6/4/13 at 1:51 P.M., LPN #7 indicated she was unable to locate any documentation Resident #18 had received prune juice, his Milk of Magnesia PRN, his Bisacodyl suppository PRN, or any additional bowel stimulant during the following time frames: March 3, 4, 5, 6, and 7, 2013; April 27, 28, 29, and 30, 2013; May 6, 7, 8, 9, and 10, 2013; May 18, 19, 20, and 21, 2013. The most current Bowel Elimination Policy provided by the Administrator on 6/4/13 at 9:20 A.M., indicated the following: "Policy: It is the policy of the facility that residents who have not had a bowel movement within three (3) days, shall be evaluated and appropriate action taken. Purpose: To ensure elimination occurs to avoid constipation and discomfort for the resident. Procedure: 1.) CNA's shall complete the BM Record to document dates(s) of bowel movements. 2.) Charge Nurses's shall review the BM Record to ensure bowel movements have occurred at least every three (3) days, in the absence of extenuating medical circumstances that would preclude a resident from eliminating the bowel at least every three (3) days. In addition, should a resident			

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	inform the staff that their normal pattern bowel movements occur more that every three (3) days, this will be discussed with the physician and documented in the medical chart. 3.) If the resident has not had a bowel movement within three (3) days (and in the absence of the above extenuating circumstances) the licenses nurse shall proceed as follows: >Obtain an order and administer a stool softener. >Provide prune juice at least daily." 3.1-37(a)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide assistance with dining and using eating utensils for 1 resident of 10 residents observed for dining. (Resident #7) Findings include: The record of Resident #7 was reviewed on 5/30/13 at 9:40 a.m. Resident #7's diagnoses, included but were not limited to, senile dementia and anxiety. Resident #7's Quarterly, MDS (Minimum Data Set), assessment, dated 4/28/13 indicated Resident #7 cognition was severely impaired, never/rarely made decisions and needed extensive assistance, one person with eating. Resident #7's, care plan, dated 4/2/12 with a update of 5/30/13, indicated "Problem #1, resident presents the potential for weight lost and problem #2, eating with fingers. Goal, the	F000312	Heritage House will continue to ensure that a resident who is unable to carryout the activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.1. Resident #7 has been evaluated and treated by both speech and occupational therapy. We have contacted the resident's family re; her eating habits. Family stated resident has eaten with her fingers for a long time. They also tried to correct this but failed. They have no concerns re: resident eating with her fingers at its her choice. The Ombudsman, was also contacted re: Resident #7 eating with her fingers. It is her opinion that the resident has the right to eat with her fingers. A spoon is provided on Resident #7 food tray, she chooses not to use it. She will at times allow staff to put the edge of the spoon in her mouth but will not eat. Staff does attempt to feed resident #7. Resident #7 has only allowed staff to assist her a very few times. The DON, MDS Coordinator and other nurses have had no success feeding the resident. This is a resident	07/04/2013

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	resident to maintain weight through next 90 days review. Interventions, honor the physician's ordered diet, pureed, monitor weight weekly for 4 weeks or until stable, then monthly, send dessert bowls on her tray resident prefers to eat with her fingers. Comment, 1/21/13, resident continues to eat with fingers. She starts out with spoon but prefers fingers." Resident #7's care plan, dated 2/20/13, "Problem, resident eats meals with her fingers and at times sucks on fingers. Goal, resident will be allowed to eat with her fingers, as she desires, as well as episodes of sucking on her fingers. Intervention, ensure that her hands are clean and provide "finger-foods", cups, or bowls for resident to use. Resident #7's physician recapitulation orders, dated 6/13, indicated "no added salt/pureed diet." On 5/28/13 at 7:34 a.m., Resident #7 was in the assist dining room. She had 3 dessert bowls of pureed food and would put her right finger in one of the bowls and the suck on her finger. She ate approximately 1/2 of her food by continuing to put her		choice issue.2. Any resident who refuses to be assisted with meal, refuses to use eating utensils, must be on a pureed diet and insists to feed self with her fingers is at risk. All residents will be audited for their preferred eating habits. Anyone who meets the aforementioned criteria will be evaluated by speech therapy and occupational therapy to see if their eating habits can be changed, if resident so desires.3. All residents who require pureed food and eat wth their fingers will be screened by speech therapy and occupational therapy to see if treatment can correct the way the resident eats. If treatment is indicated it will be provided. 4. The DON or their designee will monitor residents to identify any resident who needs assistance with eating, 5 times a week for 3 months then weekly for 3 months, then as needed. All residents identified will be referred to speech therapy and occupational therapy for evaluation &/or treatment. The report findings and treatments will be submitted to the QA Committee quarterly for 6 months, then as needed. See attachment #9 A-BIDR: There is no evidence that the facility did not provide ADL care to resident #7. Resident #7 has the right to choose to eat in any manner she wishes. See attached.	

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	finger in the food and licking her finger During an interview on 5/28/13 at 7:45 a.m., CNA #1 indicated "we try not to feed her so we can get her to eat with a spoon instead of us feeding her because she will just eat and eat until she gets sick when we feed her." On 5/29/13 at 11:58 a.m., Resident #7 was observed eating lunch by putting her finger in different dessert bowls with pureed food, mashed potatoes, pudding ground turkey. A spoon was provided but she did not use it. During an interview on 5/29/13 at 12:10 p.m., CNA #10 indicated "we don't feed her because she will eat so much she will get sick." On 5/31/13 at 12:20 p.m. CNA #6 was observed feeding Resident #7 with a spoon during the entire meal without difficulty. 3.1-38(a)(2)(D)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to follow fall interventions and implement effective fall interventions for 1 of 3 residents reviewed for falls of 4 who met criteria for falls (Resident # 3). Findings include: On 5/29/13 at 1:35 p.m. Resident # 3 was observed sitting in her wheelchair in the hallway with blue/green/yellow bruising noted all over her facial area. Record review on 6/4/13 at 9:30 a.m. indicated Resident # 3's Minimum Data Set Assessment dated 4/15/13 indicated a Brief Interview for Mental Status with a score of 05 which indicated cognition was severely impaired. Review of nursing notes dated 5/10/13 indicated "Resident yelling out at 2:45 p.m. 'help me, I've fallen out of my wheelchair.' Resident found lying in hallway in front of room. Large	F000323	Heritage House will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.1. Resident #3 continues to be encouraged to eat snacks out of room, which she continues to refuse to do. Continues to eat snacks in her room. Food and fluids are placed on bedside table to avoid spilling. Staff continues to attemp to keep room free of debris. Observation of Resident # 3 on 6/4/2013 by Administrator indicated minute pieces of debris on floor. The largest piece of brown debris (1 piece)was no large than a little fingernail. Very hard to see on a brown floor behind the residents wheelchair. Resident would not have been able to see debris. Surveyor had to brush the minute pieces into her hand, unable to pick up with fingers.2. Any resident who attempts to pick up something on the floor from a wheelchair is at risk. All residents in wheehchairs who are at risk will be evaluated by Occupational Therapy and their	07/04/2013

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	hematoma to left side of forehead and left eye... Order received to send to ER (emergency room) for evaluation and treatment." Review of Care Plan for falls dated 12/12/12, indicated Problem: Resident has multiple risk factors for falls such as:dementia, use of psychotropic medication, history of falls, decreased mobility. Goal: Resident will sustain no injuries due to fall thru next review. Approach:... Reacher provided-instructed on use 9/26/12. Discontinue does not use it. (no date) Resident to be encouraged to have snacks out of her room in view of staff 5/10/13. Staff to place food and fluids on bedside table to avoid spilling. Reacher provided- encourage her to use it if she drops something on the floor 5/29/13. Post Fall Assessment and Follow-up provided by the DON on 6/4/13 at 10:00 a.m. indicated Resident # 3 on 5/10/13 had a fall with injury. Type of injury: hematoma left forehead/eye, left knee abrasion. Interventions: What interventions were implemented? Try to keep room - hallway free from debris so Resident won't try to clean...		recommendations followed..3. All residents in wheelchairs will have a new fall risk assessment completed & referred to therapy if indicated.4. Fall notification log located with the 24 hr. report at each nurses station is to be filled out with each fall. DON or her designee will monitor 5 times weekly times 3months and weekly times 3 months., then as needed. The report will be given to the QA Committee for review and recommendations. Attachment # 1AIDR: There is no evidence that facility did not ensure resident enviroment remained as free of accident hazards as possible. See attached.	

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	1. What were you trying to do - per resident statement. Pick up popcorn dropped on the floor. Observation of Resident # 3 on 6/4/13 at 1:15 p.m., indicated she was in her room sitting in her wheelchair with a reacher lying within reach on her bed, the handle of the reacher was turn away from the Resident. Resident # 3 indicated "I don't know what that (pointing at reacher) is." Observed food particles on floor in front of the Resident. Resident # 3 was sitting in her wheelchair in her room alone, eating cheese and crackers. Observation of Resident # 3's room on 6/4/13 at 1:45 p.m. by the Administrator indicated food particles that appeared to be corn chips on the floor close to where the Resident was sitting in her wheelchair. Review of the Fall Management Policy provided by the Administrator on 6/4/13 at 9:20 a.m. indicated Purpose: 1. To determine those residents who are at risk for falling. 2. To develop a plan of care with the appropriate interventions to decrease a residents risk for falls... Procedure: 3. Document specific problems, goals and approaches on			

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	the residents care plan. 4. Review and up date the care plan with scheduled reviews or as resident's condition changes... 3.1-45(a)(2)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was prepared in a clean and sanitary environment. This had the potential to affect 48 of 52 residents who received meals from 1 of 1 dietary kitchen. Findings include: During the initial tour of the dietary department on 5/28/13 at 7:34 a.m., accompanied by the Dietary Manager the following were observed. - On the counter were drinks were prepared for the residents, a drink belonging to one of the employees, with a straw in it, 1/2 full and from a fast food restaurant, was observed among the residents' drinks. - A pail of water to clean the dietary aid counter did not have any chlorine in it. - Several gnats were observed	F000371	Heritage House will continue to maintain an effective pest control program, so that the facility will remain free of pests and rodents. 1.The pest control company treated the kitchen 5/22/13, for fruit flies, not gnats, we did not have gnats. These terms have both been used but the pest control company said it was fruit flies. It was suggested by them that the floor under the dishwasher be replaced. Maintenance replaced floor on 5/22/13. Pest control returned on 6/3/13, surveyor was made aware of this. They stated problem was getting better. They installed fruit fly traps, silent trap insect light, and treated all drains. He suggested we replace screen in exit door to kitchen. We replaced entire kitchen door on 6/11/13. We also had grease trap jetted. Attachment #12-D. Dietary developed a new procedure to clean nozzles of the juice machine. Attachment # 13.A At no time after surveyor's initial tour of dietary, did she return to check on fruit flies, even after Adm. informed her the fruit flies were much better and even after she	07/04/2013

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	155089	A. BUILDING 00 B. WING	06/04/2013

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	around the dishwasher and the juice area. An interview with the Dietary Manager on 5/28/13 at 7:50 a.m., indicated an employee had left the drink on the preparation counter, the pail of water to clean the preparation counter did not have chlorine in it and they had been having gnats. She also indicated she would look at when pest control had been there last. 3.1-21(i)(3)		was informed of 6/3/13 treatment. Surveyor's interview of resident #26 is questioned. Surveyor states, resident # 26 stated" in the dinning room there are gnats all over the wall." Resident #26 has advanced macular degeneration and has said he cannot see. This is documented on his medical record. His cognition is also moderately impaired. See attachment # 14 A-D. Pest control company returned 6/20/13 and installed commercial fly light and replaced fruit fly traps. Attachment 15.A-B. On 6/26/13 American Pest Control will do an entire pest control bomb of the dietary dept. to ensure all fruit flies are gone 2. All residents in the facility who receive food from the kitchen have the potential to be affected. The pest control company treated the kitchen 5/22/13 & 6/3/2013 for fruit flies They installed fruit fly traps, silent trap insect light, and treated all drains. 3.We will continue our monthly pest control visits. Maintenance or their designee will monitor for fruit flies (gnats) in the kitchen, dinning room and kitchenette . 4. Maintenance or their designee will monitor for fruit flies (gnats) in the kitchen, dinning room and kitchenette five times a week for 3 months, one time a week for 3 months and as needed. See attachment #16. They will report their findings to the QA Committee for review	

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			IDR: There is no evidence that the facility did not store, prepare , distribute and serve food under sanitary conditions. See attached.	

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F000469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program. There were gnats observed in the dietary kitchen, dining room and kitchenette for the residents; this has the potential to affect 52 of 52 residents residing in the facility. Findings include: During the initial tour of the dietary department on 5/28/13 at 7:34 a.m., accompanied by the Dietary Manager, gnats were observed around the dishwasher and the juice area. On 5/28/13 at 8:19 a.m., gnats were observed flying around one resident's plate during breakfast. On 5/28/13 at 11:00 a.m., gnats were observed near the sink in the resident's kitchenette. Review of a service slip/invoice, from a local pest control, dated 5/16/13, indicated during a visit to the facility the target was ants. They also checked the fly lights, baited for ants	F000469	Heritage House will continue to maintain an effective pest control program, so that the facility will remain free of pests and rodents. 1.The pest control company treated the kitchen 5/22/13, for fruit flies,. It was suggested by them that the floor under the dishwasher be replaced. Maintanance replaced floor on 5/22/13. Pest control returned on 6/3/13. They stated problem was getting better. They installed fruit fly traps, silent trap insect light, and treated all drains. He suggested we replace screen in exit door to kitchen. We replaced entire kitchen door on 6/11/13. We also had grease trap jetted. Attachment #12-D. Dietary developed a new procedure to clean nozzels of the juice machine. Attachment # 13.A. Surveyors interview of resident #26 is questioned. Surveyor states, resident # 26 stated" in the dinning room there are gnats all over the wall." Resident #26 has advanced macular degeneration and has said he cannot see. This is documented on his medical record. His cognition is also moderately impaired. See attachment # 14 A-D. Pest control company returned 6/20/13 and installed commercial fly light and	07/04/2013

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	in the laundry room and checked all monitors. Review of a service slip/invoice, from a local pest control, dated 5/20/13, indicated target was spiders and ants, and the exterior was sprayed. During an interview on 5/28/13 at 7:45 a.m., the Dietary Manager indicated they had been having some gnats in the kitchen. During an interview on 5/28/13 at 11:00 a.m., Resident #26, indicated "in the dining room there are gnats all over the wall." Resident #26's record was reviewed on 5/29/13 at 12:30 p.m. Resident #26's MDS (Minimum Data Set), assessment, dated 3/7/13, indicated Resident #26's BIMS (Brief Interview for Mental Status), scored 12, with a score of 8-12 indicating Resident #26's cognition was moderately impaired. During an interview on 6/3/13 at 10:25 a.m. the Administrator indicated the facility was aware of gnats being a problem and pest control had been to the facility on 5/16/13 and 5/20/13. She also indicated the facility was going to call pest control to come out again, and they had moved the		replaced fruit fly traps.Attachment 15.A-B. On 6/26/13 American Pest Control will do an entire pest control bomb of the dietary dept. to ensure all fruit flies are gone 2. All residents in the facility who recieve food from the kitchen have the potential to be affected. The pest control company treated the kitchen 5/22/13, for fruit flies, not gnats, we did not have gnats.. It was suggested by them that the floor under the dishwasher be replaced. Maintenance replaced floor on 5/22/13. Pest control returned on 6/3/13. He suggested we replace screen in exit door to kitchen. We replaced entire kitchen door on 6/11/13. We also had grease trap jetted. Attachment #12D. Dietary develpoed a new procedure to clean nozzels of the juice machine. Attachment # 13. . Pest control company returned 6/20/13 and installed commercial fly light and replaced fruit fly traps.Attachment #15.A-B 3.We will continue our monthly pest control visits. Maintenance or their designee will monitor for fruit flies (gnats) in the kitchen, dinning room and kitchenette. 4. Maintenance or their designee will monitor for fruit flies (gnats) in the kitchen, dinning room and kitchenette five times a week for 3 months, one time a week for 3 months and as needed. See attachment #16. They will report their findings to the QA	

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	bananas and some of the other fruit. 3.1-19(f)(4)		Committee for review and recommendations.	